Billing Instructions 1

Computer Media Claims (CMC) are processed through the same claim verification programs as paper claims. CMC and paper claims must meet the same edit and audit requirements.

Claims Acceptable Through the CMC Formats

Most claims can be submitted through CMC. This includes claims submitted within the six-month billing limit or claims submitted beyond the six-month billing limit with the appropriate billing limit exception code. Denied claims resubmitted within the six-month billing limit also are acceptable for CMC submission.

Delay Reason Code

The ASC X12N 837 v.4010A1 format uses delay reason codes 1, 3 - 6 and 11. Refer to the appropriate Medi-Cal Provider Manual submission and timeliness section for delay reason code descriptions.

Supporting Documentation:

Certain Medi-Cal claims require supporting documentation that can be noted in the *Remarks* area/*Reserved For Local Use* field ASC X12N 837 v.4010A1 Note (NTE) Segment (Box 19) of the paper claim. These claims also are acceptable for CMC submission and require using the ASC X12N 837 v.4010A1 *Note (NTE) Segments*.

The following list represents some of the circumstances under which claims may be submitted through CMC with appropriate substantiating statements in the ASC X12N 837 v.4010A1 *Note (NTE) Segments*.

- When billing with certain HCPCS or CPT-4 codes, including:

Unlisted Procedures	Include procedure description and price in the ASC X12N 837 v.4010A1 *Note (NTE) Segments*.
Unlisted Injections	Include name of drug, strength, dosage and invoice cost in the ASC X12N 837 v.4010A1 *Note (NTE) Segments*.
"By Report"	Include additional clinical information or Procedures report in the ASC X12N 837 v.4010A1 *Note (NTE) Segments*.
Unusual/ Complicated	Include complicating or unusual circumstances in Procedures ASC X12N 837 v.4010A1 *Note (NTE) Segments*.

- When billing with multiple or "By Report" modifiers (for example, -99, -51, -22).

- When submitting claims using delay reason codes 1, 3 – 6 or 11 for the ASC X12N 837 v.4010A1 format.

- When submitting claims requiring Medi-Service transactions obtained through the POS network or AEVS.
- When submitting claims for Medicare non-covered services.
- When billing for a newborn using the mother's Medi-Cal identification number.
- When including an emergency statement.
- When billing for compounded prescriptions (except TPN).
- When submitting Long Term Care claims detailing Share of Cost expenditures.

TAR Approval

Claims for services that require a *Treatment Authorization Request* (TAR) are acceptable through CMC submission. The TAR Control Number is included in the claim record as indicated in the record data specifications outlined in this Companion Guide. The provider keeps a copy of the approved TAR on file.

Claims Unacceptable Through CMC

All claims requiring hardcopy attachments or special processing must be submitted on paper claim forms, including:

Claims that require an *Explanation of Medicare Benefits/Medicare Remittance Notice/Remittance Advice* (Medicare status codes 1 – 7 and 9).

- Medicare/Medi-Cal crossover claims that must be separately billed to Medi-Cal.
- Claims including denial from Other Health Coverage (for example, CHAMPUS, Kaiser, Ross Loos, prepaid health plans).
- Claims billing HCPCS or CPT-4 codes where the price is unlisted with Medi-Cal and the submitter is unable to include the information required for pricing in the ASC X12N 837 v.4010A1 *Note (NTE) Segment*.
- Claims with delay reason codes 7, 10, or 15 on the *UB-92 Claim Form* or the *HCFA 1500* claim form.
- Claims requiring a sterilization or hysterectomy consent form.
- Claims from providers on special claims review.
- Claims for Medi-Cal recipients who have a California Children Services (CCS) -eligible condition and who are enrolled in a managed care plan that excludes treatment of CCS-eligible conditions from the plan's contract rate. These claims will be denied if submitted directly to EDS. They must be submitted to the appropriate CCS office to ensure all necessary authorizations are included. Refer to the *California Children Services (CCS) and Genetically Handicapped Persons Program (GHPP)* section in the Medi-Cal Provider Manual for additional information.
- Vision care claims for eye appliances requiring prior authorization.
- Children's Treatment Program (CTP)

Submission Balancing

Each submission is balanced by comparing the total number of claims and dollars submitted to the total number of claims and dollars processed. For tape submissions, this information must also match the total number of claims and the total dollars billed on the *Claim Certification and Control Sheet* (Form 80-1).

Billing Value Field

For balancing purposes, a *Billing Value* field is used to determine the total dollars billed. The *Billing Value* field for submitter and provider control records is defined as follows:

Submitter Control Records (created) – The submitter *Billing Value* is the total of the individual *Billing Value* fields on each *Provider Control Record*.

Provider Control Record (created) – The *Billing Value* is the total of all *Amount* fields for that provider and claim type as defined below:

- Medical/Allied *Net Amount Billed*
- Outpatient *Net Amount Billed*
- Inpatient *Net Amount Billed*
- Vision *Net Amount Billed*
- LTC *Net Amount Billed for Each Line*

The fields on the *Claim Certification and Control Sheet* must agree with the fields in the *Submitter and Provider Control Records*.

Rejected Submissions

The entire CMC submission may be rejected if a balancing or data error is located in the *Submitter Control Record*. If the error is located in a *Provider Control Record*, claims for that particular provider will be rejected. If an error is located in a *Claim Record*, only that particular claim will be rejected.

Complete File Rejection

When an entire submission containing Medi-Cal claims fails CMC edit requirements, the submitter is sent a *CMC Submission Error Listing* (CP-O-012) and *CMC Submission Balancing Control Report* (CP-O-112) indicating the errors. (See *Figures 1* and *2* on a following page for examples of these reports.). Rejected tapes are returned to the submitter along with the *Claim Certification and Control Sheet*.

Note: Submission error information can also be accessed on the Medi-Cal Web site at *www.medi-cal.ca.gov.*

Partial Rejection

The CP-O-012 and CP-O-112 are also sent to the submitter if the submission is partially rejected at either the *Provider Record* or *Claim Record* level. The submitter should make the appropriate corrections and resubmit the corrected claims. Tapes with partially rejected files are held for 14 days as required by DHS.

Note: Error report information can also be accessed on the Medi-Cal Web site at *www.medi-cal.ca.gov*.

REPORT NO. CP-O-012 CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM PAGE 1
REPORT DATE 10/15/92 CMC SUBMISSION ERROR LISTING RUN ON 10/15/92 AT 18 29

SUBMITTER NUMBER	SUBMITTER NAME	HDR CLAIM COUNT	HDR BILL AMOUNT	HDR ATTACH COUNT	DATE SUBMITTED	DATE RECEIVED	REEL #	EDS VOL-ID	MEDIA TYPE
999	HAPPY HEALTH CENTER	3,350	$ 129,136.93	0	09-27-92	/ /	496233	T	

SUBMITTER LEVEL ERROR - PLEASE RESUBMIT ALL CLAIMS FOR THIS SUBMITTER VOLUME
ERROR 039: TAPE-RECEIPT RECORD WAS NOT MATCHED TO SUB CTL RECORD

CLAIM LEVEL ERROR - PLEASE RESUBMIT THE FOLLOWING CLAIM:

PROVIDER NUMBER	CLAIM TYPE	CLAIM SEQ NUM	REC SEQ NUM	PROVIDER ACCOUNT #	RECIPIENT ID	RECIPIENT LAST NAME	SERVICE DATE	AMOUNT BILLED
ZZT12345F	04	0445	0	3722233	550432333	SMITH	00/00/00	$ 0.00

ERROR 034: AMOUNT FIELD OF A CLAIM WAS NOT NUMERIC

CLAIM LEVEL ERROR - PLEASE RESUBMIT THE FOLLOWING CLAIM:

PROVIDER NUMBER	CLAIM TYPE	CLAIM SEQ NUM	REC SEQ NUM	PROVIDER ACCOUNT #	RECIPIENT ID	RECIPIENT LAST NAME	SERVICE DATE	AMOUNT BILLED
ZZT12345F	04	0446	0	3722233	550432333	SMITH	00/00/00	$ 0.00

ERROR 034: AMOUNT FIELD OF A CLAIM WAS NOT NUMERIC
PROVIDER LEVEL ERROR - PLEASE RESUBMIT ALL CLAIMS FOR THE FOLLOWING PROVIDER: ZZT12345F CLAIM TYPE = 04
ERROR 011: AMOUNT BILLED ON PROV CTL REC DOES NOT BALANCE
ERROR 031: AMOUNT BILLED ON SUB CTL REC DOES NOT BALANCE

Figure 1. Sample CMC Submission Error Listing (CP-O-012)

REPORT NO. CP-O-112 CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM PAGE 1
REPORT DATE 10/15/92 CMC SUBMISSION BALANCING CONTROL REPORT RUN ON 10/15/92 AT 18 29

SUBMITTER NUMBER	SUBMITTER NAME	SUBMITTER ADDRESS	SUBMITTER STATUS	DATE RECEIVED	REEL #	EDS VOL-ID	MEDIA TYPE
999	HAPPY HEALTH CENTER	1234 WARDEN WAY ATTN: TERRY CREEL CITRUS HEIGHTS CA 95610	ACTIVE	/ /		496233	T

HEADER PROVIDER COUNT	PROCESS PROVIDER COUNT	HEADER CLAIM COUNT	PROCESS CLAIM COUNT	HEADER BILLED AMOUNT	PROCESS BILLED AMOUNT	HEADER ATTACH COUNT	PROCESS ATTACH COUNT
1	1	3,350	3,350	$ 129,136.93	$ 129,155.68	0	0

* * * UNABLE TO MATCH THE TAPE TO ANY RECORD ON THE TAPE RECEIPT FILE * * *

Figure 2. Sample CMC Submission Balancing Control Report (CP-O-112)

CMC ANSI ASC X12N 837 v4010A1: INPATIENT/OUTPATIENT/LTC AND MEDICAL/VISION SERVICES

Submission Methods

ANSI ASC X12N 837 v.4010A1 Health Care Claim transactions may be submitted through the CMC system for providers who bill inpatient, outpatient, long term care, vision, medical and allied health claim types. The ANSI ASC X12N 837 v.4010A1 transaction record format is described in the *CMC ANSI ASC X12N 837 v.4010A1 Institutional Data Specifications or ANSI ASC X12N 837 v.4010A1 Professional Data Specifications* sections. Data elements included in a submission are either required for ANSI standard transactions or Medi-Cal claims processing.

For an explanation of the ANSI (American National Standards Institute) ASC (Accredited Standards Committee) 4010A1 standards and various data values, refer to the appropriate ANSI ASC X12N v.4010A1 standards documentation available.

Medi-Cal's CMC file transfer procedures and submission protocol do not change with ASC X12N 837 v.4010A1 submissions. The ASC X12N 837 v.4010A1 transaction can be used in place of the Medi-Cal CMC *Submitter Control, Provider Control, Claims and Remarks records*.

Submission Balancing

Each ASC X12N 837 v.4010A1 transaction is verified by the *Receiver ID* on the transaction. Claim totals must balance with the claim record received. For balancing purposes, any ASC X12N 837 v.4010A1 transaction that is not processed in its entirety will be rejected.

Rejected Submissions

The entire ASC X12N 837 v.4010A1 CMC submission will be rejected if the *Receiver ID* is not "610442" and all claims on a transaction are not processed.

PRODUCTION ERRORS, RADS AND CIFS

Production Errors and Solutions

ASC X12N 837 v.4010A1 submissions are reviewed for production errors. Providers will be notified of formatting infractions by one of the following methods:

Submission error Notification

The CMC Help Desk staff notifies the submitter by phone each time a production error is encountered.

Note: Submitters can also access this information on the Medi-Cal Web site at *www.medi-cal.ca.gov*.

Six-Month Billing Limit

Errors indicated on Report CP-O-012 and CP-O-112 should be corrected and the claim(s) resubmitted within the original six-month billing limit.

Production Claim Failure: Common Causes and Solutions

The *Production Claim Failure: Common Causes and Solutions* is a listing of common submission, production data and file errors with their solutions. Refer to *Charts 1*, *2* and *3* at the end of this section. Submitters may also call the CMC Help Desk for help in correcting production and submission errors.

Remittance Advice Details (RAD)

RAD statements include all provider claims submitted by tape, telecommunications and hardcopy. CMC claims are identified by roll numbers 45 - 47 and 60 - 65 in the fifth and sixth digits of the Claim Control Number (CCN).

Automated Remittance Data Service (ARDS)

Electronic RAD files are available on tape or can be downloaded from the Medi-Cal Web site at *www.medi-cal.ca.gov* through a separate contract with EDS. Contact the CMC Help Desk for further information concerning the Automated Remittance Data Service (ARDS) or refer to the *Remittance Advice Details (RAD): Electronic* section in the Medi-Cal provider manual.

ANSI ASC X12N 835 Transaction

The ANSI ASC X12N 835 transaction known as the *Electronic Health Care Claim Payment/Advice* form is available for downloading on the Medi-Cal Web site at *www.medi-cal.ca.gov* effective October 1, 2003. The 835 transactions are available by the Medi-Cal warrant date. Contact the CMC Help Desk for information about the 835 transaction or refer to the *Remittance Advice Details (RAD): Electronic* section in the Medi-Cal Provider Manual.

Claims Inquiry Form

Resubmission of claims denied for exceeding the six-month billing limit and adjustments to previously paid claims require a *Claims Inquiry Form* (CIF). For more information regarding the CIF process, please refer to the *CIF Overview* section in the Medi-Cal Provider Manual.

Note: If a claim is denied for exceeding the six-month billing limit because the billing limit exception code or substantiating remarks text was missing from the original CMC submission, the claim may be corrected and resubmitted through CMC.

Claims excluded from CMC billing for one of the above reasons are denied with RAD code 263 and the following message:

> Computer media supporting remarks are not acceptable for this procedure due to the requirement for invoice, current catalog page, or other hardcopy form or signature.

Production Claim Failure: Common Causes and Solutions

Claims Certification (Medi-Cal Submissions) and Control Sheet Errors (CMC Tape)	Solutions
Total Claim Records does not agree with the total of the *Number of Claims* for each provider ID.	Ensure accuracy of addition and ensure that numbers are not transposed.
Submitter number and/or *name* and address are missing.	Ensure all fields are completed.
ID Number contains a number other than a valid CMC file identification or field is blank.	See the *ASC X12N 837 v.4010A1 Tape Submissions* section for format of this nine-character field.
If a photocopy of form is submitted, copy does not include both sides of document and/or original signature.	Ensure that both sides of the form are photocopied and submitted and that the copied form includes an original signature.
Medi-Cal Data Errors	**Solutions**
Claim count or billed amount on the *Submitter Control Record*, the *Provider Control Record(s)*, and/or the *Claim Records* does not balance.	All claim controls and billed amounts on a file must balance. For tape submitters, they must also agree with the *Claim Certification and Control Sheet*.
Line number outside valid range for claim type. This Medi-Cal CMC formats (all claim types).	Valid detail line numbers for claim types are: 01 – 06 Long Term Care 01 – 15 Inpatient 01 – 14 Outpatient 01 – 08 Medical 01 – 07 Vision
Duplicate *Provider Control Records*.	There may be only one *Provider Control Record* for each provider number/claim type combination.
Submission date exceeds process date.	This error often results from the assumption that the submission date is the date EDS will process the file. Avoid this error by using the date when CMC billing files are created.
Provider not in active status.	Do not submit claims for providers who are pending approval for CMC billing. This causes provider's claims to reject. For verification of a submitter to provider status, call the CMC Help Desk before submitting a claim.

Chart 1: Claim Certification and Control Sheet Errors and Medi-Cal Data Errors

Production Claim Failure: Common Causes and Solutions

ASC X12N 837 v.4010A1 **Data Errors**	**Solutions**
Receiver ID not valid.	Verify file should be Medi-Cal. Correct *Receiver ID*.
Claim totals do not balance with claim records received.	Verify data on file for required segments, elements and subelements or required record types.
Line number outside valid range for claim type.	Valid detail line numbers for claim types are: 22 Inpatient and Outpatient 8 Medical 6 Vision 1 LTC

Chart 2: ASC X12N 837 v.4010A1 Data Errors